CAPITAL HEALTH LAWRENCE OBGYN ASSOCIATES

Name:_____ DOB:_____

Reason for appointment:_____

Referring Physician:_____ Primary Care Physician:_____

Have you seen an OBGYN before? Y / N If so, who?_____

Allergies (medications, foods, latex, iodine etc. Please write allergy and the problem):

Medications and herbal supplements (include dosage and frequency):

Vaccines/Immunizations:

Did you receive the Gardasil Vaccine for HPV? [ ] Yes [ ] No If yes, did you receive all 3 doses? [ ] Yes [ ] No
Did you receive a Flu Vaccine? [ ] Yes [ ] No If yes, when? _____
Have you had a Tdap Vaccine? [ ] Yes [ ] No If yes, when? _____

Problems/Medical History:

(Check off if you currently have or have had any of these medical problems in the past)

	Abuse/Domestic Violence		Cardiac problem		Kidney Disease or Bladder problem
	Acid Reflux/ GERD		Depression		Lung Disease/ Respiratory Illness
	Acne		Dermatology problem/Eczema		Neurologic Disease
	ADD/ADHD		Diabetes- Medication controlled		Osteopenia/Osteoporosis
	Anemia		Diabetes- Diet controlled		Polyps
	Anesthesia Complications		Diabetes- Gestational/Pregnancy		Pre-Eclampsia
	Anxiety Disorder		Eating Disorder		Psychiatric Illness
	Arthritis/Fibromyalgia		Endocrine problem		Stroke
	Asthma		GI problem		Thyroid Disease
	Autoimmune/Rheumatology problem		Headaches/ Migraines		Vascular Disease
	Birth Defects/Inherited Disease		Heart Disease		Varicosities/Vein Problem
	Bleeding Disorder		Hepatitis		Weight Gain
	Blood Transfusion		High Cholesterol		Weight Loss
	Cancer: _____		Hypertension		Other:_____

Gynecological Problem History:

(Check off if you currently have or have had any of these medical problems in the past)

	Fibroids		Infertility		Genital Herpes
	Gonorrhea		Ovarian Cancer		HIV
	Endometriosis		Breast Cancer		Chlamydia
	Ovarian Cysts		Cervical Cancer		Pelvic Inflammatory Disease (PID)
	Syphilis		Uterine Cancer		Genital Warts

Gynecologic/Menstrual History:

Date of your last menstrual period? _____

How often do you get your menstrual cycle? Every _____ days, lasting for _____ days

Is your menstrual flow: [ ] Light [ ] Moderate [ ] Heavy Are your cycles? [ ] Regular [ ] Irregular

Age at first period: _____ If menopausal, age of menopause: _____

Have you had a Pap smear? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Have you had abnormal pap? [ ] Yes [ ] No If yes, when:_____

Have you ever had a colposcopy? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Are you sexually active? [ ] Never [ ] Not currently [ ] Yes

Is your partner: [ ] Male [ ] Female [ ] Both

Have you ever had a mammogram? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Have you ever had a colonoscopy? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Have you ever had a DEXA/Density Scan? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Method of Contraception/Birth Control:

(Check all that apply)

[ ] Pregnant	[ ] Rhythm Method	[ ] Essure
[ ] Nuva Ring	[ ] Depo Provera	[ ] Seeking Pregnancy
[ ] Withdrawal	[ ] Implant	[ ] Vasectomy
[ ] Condoms	[ ] IUD	[ ] Pill
[ ] Patch	[ ] Tubal Ligation	[ ] None

Obstetric/Pregnancy History:

Total number of: Pregnancies:_____ Full Term Births:_____ Pre-Term Births:_____

Living Children:_____ Abortions Induced:_____ Miscarriages:_____

Age at first Live Birth:_____

No.	Birth Date	# Weeks at Delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1							
2							
3							
4							
5							
6							
7							
8							

Family Medical History:

Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: [ ] No Family History [ ] Adopted

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Father (Maternal)	Grand Mother (Paternal)	Grand Father (Paternal)	Aunt (Maternal)	Uncle (Maternal)	Aunt (Paternal)	Uncle (Paternal)
Blood Clots													
Breast Cancer													
Cervical Cancer													
Colon Cancer													
Diabetes													
Ovarian Cancer													
Hypertension													
Stroke													
Uterine Cancer													
Other Cancer not mentioned													
Other Disease not mentioned													

Do you or have you smoked tobacco? (cigarette/cigar/etc)	No Yes (currently) Yes (former)	[ ] Every day, _____ per day/# of years_____ [ ] Some days, describe:_____ [ ] Former, Quit:_____ years ago
Have you ever used smokeless tobacco (vape/e-cig/chewing tobacco)?	No Yes (currently) Yes (former)	[ ] Every day, _____ per day/# of years_____ [ ] Some days, describe:_____ [ ] Former, Quit:_____ years ago
Do you drink alcohol?	No Yes	[ ] Social [ ] Daily How many drinks per week? _____
Have you ever used illicit drugs?	No Yes	If yes, when and what kind:

OBGYN Surgical History:

(Please write date of surgery below)

√	Surgery/Year	√	Surgery/Year	√	Surgery/Year
	D&C		Hysterectomy (abdominal)		Left Ovary removed
	Hysteroscopy		Myomectomy		Right Ovary removed
	Infertility surgery		Biopsy		Vaginal Prolapse
	Tuboplasty		Ovarian surgery		Bladder Repair/Incontinence
	Tubal Ligation		Left Ovarian Cyst removal		Colposcopy
	Laparoscopy		Right Ovarian Cyst removal		LEEP
	Hysterectomy (vaginal)		Cesarean Section		Other:_____

Non-OBGYN Surgical History:
(Please list any other surgeries with dates)

Surgery	Date	Complications?

Do you have any cultural/religious practices that may affect your treatment? [ ] Yes [ ] No

If so, what:_____

What is your present occupation?_____

General & Financial Consent: Capital Health Medical Group

Consent for Treatment:

I consent to be treated by Capital Health Medical Group under the care of my physician, his/her associates, partners, assistants and designees. I consent to care which encompasses routine laboratory, diagnostic or medical/surgical treatment advisable during treatment. I agree to allow medical students, interns and residents, under the supervision and direction of a physician to observe my treatment and review my medical record. I understand no guarantees have been made to me about the outcome of this care. I acknowledge Capital Health has the authority to dispose of specimens taken for laboratory and pathology examinations.

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Financial Agreement:

I agree whether I sign as a representative of the patient or as the patient, that in consideration of the services to be rendered to me, I obligate myself to pay the account of Capital Health Medical Group in accordance with the regular rates and terms of the group. I intend to be legally bound, assume full responsibility for and agree to pay Capital Health upon presentation of the bill, all expenses and charges for such services and care. Should the account be referred to an attorney for collection, I shall reimburse Capital Health reasonable attorney's fees and collection expense.

Medicare Authorization for Information and Payment Request Release:

I agree the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to Social Security Administration or its intermediaries or carriers or to the Professional Review Organization any information needed in order to process payment for this visit or a related Medicare claim. I request that payment or authorized benefits be made on my behalf, if I am a member of a Medicare Risk Contracting Health Maintenance Organization.

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to Capital Health Medical Group for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

Release of Information:

I assign benefits payable for physicians' services to the physician or provider furnishing services and authorize such physician or provider to submit a claim containing information related to my treatment, to Medicare, Medicaid or other insurance Carrier for payment. I understand that if under Medicare Program Guidelines, as necessary, Capital Health Medical Group is required by various governmental agencies to review and release patient information. Capital Health Medical Group also cooperates with various agencies by providing statistics and medical information for research purposes. I understand and agree that Capital Health is authorized to review and release such information. I understand that these records will contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Any specimens taken from my body during my treatment may be retained, preserved, used for teaching purposes, or disposed of by Capital Health Medical Group.

Consent to Release Medical Records:

I authorize the release of my medical records and information for the purpose of coordinating care and discharge planning and for the purpose of my follow-up care, this includes designated Care Giver, if elected. I understand that the information disclosed may include Specially Protected Health Information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment and or HIV information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment, and/or HIV/AIDS diagnosis, treatment or testing. I may revoke this authorization as it relates to Specially Protected Health Information by providing written notice to Capital Health Medical Group.

Consent for Blood Test:

In the event a physician, employee, worker or student is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids, I consent to having my blood tested for Human Immunodeficiency Virus (HIV, the virus that causes Acquired Immune Deficiency Syndrome, AIDS). Such testing will allow any necessary treatment of the physician, employee, worker or student to begin without delay. I further understand that if such testing is required I will receive appropriate counseling. The results of the test will be released only to those involved with the medical treatment of the exposed physician, hospital employee, worker or student or as required by law or as agreed to by me.

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Acknowledgment of Privacy Notice: I acknowledge receipt of Capital Health Notice of Privacy Policy.

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Patient Name: _____ DOB: _____ Date: _____

Living Will:

Do you have a Living Will and Durable Power of Attorney? **YES** **NO**

If **YES**, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart. Thank you.

If **NO**, would you like more information regarding this subject? **YES** **NO**

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., Please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. I AUTHORIZE THE FOLLWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date Signed: _____
(Patient Signature)

Signing this form verifies all information is correct and /or has been updated.

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Medication History & Medication Benefits Consent

I give permission for Capital Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health.

Patient Signature: _____ Date: _____

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Authorization for Patient Access/Release of Health Information

Patient Name:	Medical Record #:
Date of Birth:	Phone #:
Home Address: City: State: Zip:	

1. Type of Request: I hereby request the following:

☐ Access to review my original medical record ☐ Release/Disclosure of my health information, as requested below

☐ Request my medical records from another facility *Name of Facility:* _____

2. Description of Information To Be Released: *(Check ALL that apply)*

☐ Abstract* (defined below)	☐ Entire Medical Record	☐ History and Physical	☐ Operative Reports
☐ Immunization Record	☐ ER Record	☐ Progress Notes	☐ X-ray Reports
☐ Outpatient Records	☐ Consultation Reports	☐ EKG/EEG	☐ Discharge Summary
☐ Treatment Record	☐ Labs	☐ Other *(specify)*: _____	

Date of Service _____

*(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)*

I understand that the specific information to be released may include reference to alcohol abuse, drug abuse, AIDS/HIV infection, sexually transmitted diseases, tuberculosis, and/or psychiatric conditions and the treatment of any of these disorders. If this information is documented in my medical record, I agree to the release of it.

3. Disclose/Send Information To:

☐ Myself *(the patient or authorized representative)* ☐ To Organization/Individual below:

Organization:	Individual Name:		Phone #:
Street Address: City:	State:	Zip Code:	☐ Please Mail ☐ Please prepare for pick-up

4. Purpose of Release: I authorize Capital Health to release my health information for the following specific purpose: _____

5. Term/Expiration:

I understand that by law, I do not have to release this information and I choose to do so voluntarily. I may cancel this authorization by providing a written revocation to Capital Health, Health Information Management Department at either campus. This authorization will automatically expire twelve (12) months from the date listed below. *I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.*

6. Fees:

Capital Health charges a reasonable fee for retrieval of medical records and preparation of photocopies for purposes other than patient care.

Signature of Patient or Patient's Representative Date

Relationship to Patient Witness Signature

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MEDICAL GROUP

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel and/or Reschedule Your Appointment

To cancel or reschedule an appointment, please call the respective practice office.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24-hour** advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your appointment history as a "no-show".

Missed Appointment Fees

- Patients who fail to keep an appointment will be rescheduled once upon request: **No Charge**
- After a second and subsequent missed appointment: **$25 fee billed to your account**
- Third missed appointment: **Possible discharge from our practice**

Patient Name: _____

Patient Signature: _____ **Date:** _____